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MEDICAID MEMO

TO: All Pharmacy Providers and Managed Care Organizations (MCOs) Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/31/2016

SUBJECT: Pharmacy Fee-for-Service Reimbursement Methodology–Effective January 9, 2017

The purpose of this memorandum is to inform providers about changes to Virginia Medicaid's fee-for-service pharmacy reimbursement methodology that will be effective on January 9, 2017.

Virginia's Department of Medical Assistance Services (DMAS) is implementing a new drug pricing methodology to reimburse pharmacies that dispense covered outpatient drugs to Medicaid members enrolled in the fee-for-service program. Effective January 9, 2017, DMAS' pharmacy reimbursement methodology will be based on the average acquisition cost (AAC) of a given covered outpatient drug using National Average Drug Acquisition Cost (NADAC) files. The NADAC, published by the Centers for Medicare and Medicaid Services (CMS) and updated weekly, is a more accurate reflection of ingredient cost of the medications covered by the DMAS drug benefit program.

DMAS will reimburse pharmacy providers based on the NADAC for the ingredient cost and a professional dispensing fee more in line with the true cost of dispensing. This fee is based on a cost-of-dispensing survey conducted of Virginia pharmacies enrolled with DMAS. The professional dispensing fee will be $10.65.

New Pharmacy Reimbursement Methodology:
Payment for covered outpatient legend and non-legend drugs shall be the lowest of:

1. The National Average Drug Acquisition Cost (NADAC) of the drug;
2. When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; or
3. The Federal Upper Limit (FUL); or
4. The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

The pharmacy reimbursement methodology applies to:

- Drugs dispensed by retail community pharmacies

- Specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail
- Drugs dispensed by institutional or long-term care facilities
- Clotting factor

340B covered entities and Federally Qualified Health Centers (FQHCs) that fill prescriptions for Medicaid members with drugs purchased at prices authorized under Section 340B of the Public Health Services Act must bill Medicaid their actual acquisition cost (AAC). 340B covered entities that fill Medicaid member prescriptions with drugs **not** purchased under the Section 340B of the Public Health Services Act will be reimbursed as described above plus a professional dispensing fee. DMAS shall not accept claims from "contracted pharmacy entities" for drugs purchased through a 340B program.

Facilities purchasing drugs through the Federal Supply Scheduled (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program shall bill Medicaid their actual acquisition cost (AAC).

Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall bill Medicaid their actual acquisition cost (AAC). *Nominal Price as defined in* §447.502 of the Code of Federal Regulations, Part 42 *means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed*.

Payment for pharmacy services will be as described above; however, payment for covered outpatient legend and non-legend drugs shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR 447.502, per month for each specific drug. Exceptions to the monthly dispensing fees may be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be $10.65.

NCPDP Prescription Claims Processing 340B Identifier

Effective January 7, 2017, pharmacy providers submitting claims through the point-of-sale (POS) for drugs purchased through the 340B program must identify the drug as a 340B purchased drug by populating the Submission Clarification Code (42Ø-DK) field with a value of "20" **and** the Basis of Cost Determination (42Ø-DN) field with a value of "08". In addition, the pharmacy must submit the ingredient cost (i.e., 340B acquisition cost) utilizing the provider submitted ingredient cost NCPDP field 409-D9 Ingredient Cost Submitted. Note, this is a change from submission instructions detailed in the Medicaid Memo dated June 5, 2014. The 340B covered entity must submit an acquisition (Ingredient Cost Submitted or U&C) that is at less than or equal to the 340B "ceiling price". The following NCPDP denial edits and/or Virginia Medicaid edits may be posted if the claim is not submitted correctly:

- **8R = Submission Clarification Code Not Supported.** (DMAS edit = 1621) The billing provider is not enrolled with Virginia Medicaid as a 340B entity.
- **34 = M/I Submission Clarification Code**. (DMAS edit = 1620)
- **DN = M/I Basis of Cost Determination**. (DMAS edits = 1238, 1620 or 1622)
- **23 = Submitted Ingredient Cost Greater than Allowed Amount for 340B** (DMAS edit = 1623). The submitted ingredient cost is greater than the Virginia Medicaid allowed amount and

the Submission Clarification Code = 20 and the Basis of Cost = 8, the claim will deny. NOTE: Claims will continue to deny if the U&C is missing or invalid for existing DMAS edit = 0014.

Frequently Asked Questions

In addition to the frequently asked questions (FAQ) listed below, CMS has responded to questions raised by various stakeholders regarding the Covered Outpatient Drug Final Rule with Comment (final rule) (CMS-2345-FC) that was published in the Federal Register on February 1, 2016. The CMS FAQs can be accessed at **https://www.medicaid.gov/federal-policy-guidance/downloads/faq070616.pdf**

1) Why is Virginia changing its pharmacy reimbursement methodology?

State Medicaid agencies reimburse participating pharmacy providers for covered outpatient drugs that are prescribed and dispensed to Medicaid beneficiaries. The payment consists of two parts: 1) reimbursement for drug ingredient costs, and 2) reimbursement for the cost of dispensing. In general, federal regulations require that Medicaid programs reimburse for drug ingredient costs at no more than the agency's best estimate of the acquisition cost for a drug. On February 2, 2016, CMS released the Covered Outpatient Drugs final rule (CMS-2345-FC) (81 FR 5170) concerning final regulations pertaining to reimbursement for covered outpatient drugs in the Medicaid program. The revised requirement in 42 §CFR 447.512 (B) requires states to reimburse at an aggregate upper limit based on actual acquisition cost (AAC) plus a professional dispensing fee established by the agency.

2) What is the National Average Drug Acquisition Cost (NADAC)?

NADAC is a drug pricing benchmark published by CMS.

3) How are NADAC prices determined?

The NADAC pricing benchmark is determined by national surveys. The survey process focuses on retail community pharmacy drug ingredient costs. The survey collects acquisition costs for covered outpatient drugs purchased by retail community pharmacies, which include invoice purchase prices from independent and chain retail community pharmacies. A detailed explanation of the methodology used to determine NADAC can be found at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf

4) Who publishes NADAC?

The Centers for Medicare and Medicaid Services

5) How often are NADAC prices reviewed and update?

NADAC prices are continuously reviewed and updates are posted online by CMS weekly on Wednesdays. NADAC price in the pharmacy claims processing system will be updated during the weekly First Databank file update that occurs every Wednesday.

6) Are NADAC prices posted online?
Yes. NADAC prices are posted on-line at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Pharmacy-Pricing.html. NADAC prices may also be available through your drug file compendia (e.g. First Databank™ or Medi-Span®)

7) What if a drug does not have a NADAC price?

Claims for drugs without a NADAC will be processed just like a claim for a covered drug is currently processed if there is no MAC. If a covered drug does not have a NADAC price then the claim will be process using the lesser of WAC or the submitted ingredient cost.

8) Is there a help desk phone number or email address where I can contact someone at CMS about price changes?

Yes. The Centers for Medicare and Medicaid Services' contractor responsible for the NADAC, Myers and Stauffer, has a help desk that you can contact via phone or email to initiate a NADAC price review. The toll-free help desk phone number is (855) 457-5264 and the email address is info@mslcrps.com. If you choose to contact the help desk by phone you may leave a message which will be returned by a Myers and Stauffer staff member. Please note that the Myers and Stauffer help desk will only be able to address NADAC pricing issues. All other claims processing issues, including pricing and payment issues not related to the actual NADAC prices will continue to be handled by the Pharmacy Call Center at (800)774-8481.

9) If I contact Myers and Stauffer help desk about a pricing change, will I be directly notified of the outcome of the review?

No. Contacting the Myers and Stauffer help desk will prompt a review of the posted NADAC price. If the review identifies the NADAC for a covered outpatient drug has changed, the NADAC price will be revised with the following week's update. You are encouraged to monitor the weekly NADAC price list posting following a request for review at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Pharmacy-Pricing.html.

10) If my pharmacy purchases a medication above or below the posted NADAC prices does that mean that there is something wrong with the NADAC?

No; however, pricing changes do occur and it is important to contact Myers and Stauffer help desk if the posted NADAC price is below your acquisition cost. The NADAC is an average of the national acquisition costs from the sampled pharmacies with the high and low outliers (> 2 standard deviations from the mean) excluded. Some pharmacies will purchase medications below the NADAC and some pharmacies will purchase medications above the NADAC. While the NADAC represents a range of acquisition costs, the NADAC prices have a small average margin of error of 0.5% for brand name drugs and 2.4% for generic drugs at a 95% confidence level.

11) Can I submit all pharmacy invoices to Myers and Stauffer to be used in the NADAC calculation?

No. At this time, Myers and Stauffer is only accepting invoices from the pool of pharmacies randomly sampled each month. If your pharmacy is surveyed, you are encouraged to respond; however, you are not required to respond. If you are contacting the Myers and Stauffer help desk

because your acquisition costs are below the published NADAC price, you should be prepared to supply a copy of your invoices as part of the review.

12) How often could my pharmacy be selected to be surveyed by Myers and Stauffer?

Between 2000 and 2500 pharmacies nationwide are randomly selected to be surveyed every month. If your pharmacy is surveyed, there is a 5% or less chance that your pharmacy will be selected again during the same year.

13) What kinds of drugs may not have a NADAC?

Drugs that are normally administered in a clinic or hospital setting or those not generally dispensed through retail community pharmacies will not have a NADAC price as no acquisition cost data is being collected on these drugs. Drugs with very low utilization may not have a NADAC price. New drugs would not immediately have a NADAC price.

14) What is the best source of information about the NADAC and the NADAC prices?

The best source of information is the CMS website at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Survey-of-Retail-Prices.html or https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Pharmacy-Pricing.html. These websites contain information about the NADAC, the current and historical NADAC prices, the survey process and copies of archived NADAC materials.

15) Will Virginia still reimburse drugs based under the Maximum Allowable Cost (MAC) or Specialty Maximum Allowable Cost (SMAC) programs?

No. DMAS will no longer use MAC or SMAC in its reimbursement methodology.

16) Will Virginia's Managed Care Organizations (MCOs) be required to follow the same pharmacy reimbursement methodology?

No.

17) Will NADAC be used to reimburse drug submitted as medical claims on the 1500 or UB forms?

No. The new drug pricing methodology will be used to reimburse participating pharmacies that dispense covered outpatient drugs to Medicaid members enrolled in the fee-for-service program.

18) How will DMAS determine the professional dispensing fee?

Virginia will conduct a cost-of-dispensing (COD) survey at least every 5 years to determine the professional dispensing fee. The most recent COD survey was conducted by Myers and Stauffer in 2014.

DMAS Contact Information for Participating Pharmacies

Provider Information	Telephone Number(s)	Information Provided
Pharmacy Call Center	1-800-774-8481	Pharmacy claims processing questions, including transmission errors, claims reversals, obsolete date issues, etc.
Preferred Drug List (PDL) & Service Authorization Call Center	1-800-932-6648	Questions regarding the PDL program, service authorization requests for non-preferred drugs, service authorization requests for drugs subject to prospective DUR edits
Maximum Allowable Cost (MAC) and Specialty Maximum Allowable Cost (SMAC) Call Center	1-866-312-8467	Billing disputes and general information regarding multi-source drugs subject to the MAC program, and billing disputes and general information related specialty drugs subject to the SMAC Program
Provider Helpline	1-800-552-8627 In state long distance 1-804-786-6273	All other questions concerning general Medicaid policies and procedures
MediCall	1-800-884-9730 or 1-800-772-9996	Automated Voice Response System for Verifying Medicaid Eligibility
Medicaid Managed Care Organization (MCO) Information	Anthem 1-800-901-0020 Aetna 1-800-279-1878 Kaiser 1- 855-249-5025 INTotal 1-855-323-5588 Optima 1-800-881-2166 VA Premier 1-800-828-7989	Questions relating to Medicaid members enrolled in Medicaid Managed Care Plans

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COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx to learn more.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid

Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.